

Date: _____

Completed by: _____

SWIA IA Mental Health Court Referral/Intake Form

NAME: _____

D.O.B: _____

Medicaid # _____

BOOKING #: _____

REFERRAL by: _____

ADDRESS/PHONE (OUT OF CUSTODY): _____

Veteran: Yes / No Substance Abuse: Yes / No

RELEVANT MENTAL HEALTH INFORMATION:

Burgess MHC CHI HEALTH (CB, MS Valley, Red Oak) CASS MH Clarinda MHI JENNIE EDMUNDSON HFS Lasting
Hope Myrtue MC InRoads to Recovery SWIA MHC Waubonsie MHC

Other County: _____ Currently under a committal? Yes / No

History of Committal orders: Yes / No (can only ask if applicant has met with their attorney)

Parole/Probation Officer: _____ Attorney: _____

Therapist/Doctor: _____ IHH Provider: _____

MEDICATION: (circle ALL prescribed medications- BLUE = Current / RED = Past)

Abilify Ativan Benadryl Buspar Celexa Codeine Cogentin Depakote Dextyrel Dilantin Effexor Geodon Haldol Hydrocodone Klonopin
Latuda Lexapro Lithium Mellaril Morpine Neurontin Oxycodone Paxil Proloxin Prozac Remeron Restoil Risperdal Seroquel Serzone
Tegretol Thorazine Topomax Trazodone Trilafon Vistaril Welbutrin Xanax Zoloft Zyprexa Other: _____

Diagnosis: _____

RELEVANT MEDICAL INFORMATION: (circle any current illness)

Alzheimer Arthritis Back Pain Brain Injury Chronic pain Cancer Diabetes Epilepsy Heart Condition Hepatitis High Blood Pressure HIV/AIDS

Other: _____ Disability: _____

Prescribed Medical Medications: _____

Education: Graduated H.S.: Y / N G.E.D: Y / N Special Education: Y / N College: Y/N

Last School Attended: _____ Year Graduated: _____

Income/Benefits: (circle all relevant choices)

IA Wellness Plan IHH Employed FIP GA Medicare Medicaid Private Insurance SWIA MHDS Case management
Social Security SSI

Current employment: _____

Current Support Services: _____

Family Contacts:

Name: _____ Relation: _____

Address: _____

Phone: _____ Cell: _____

Name: _____ Relation: _____

Address: _____

Phone: _____ Cell: _____

OFFICE USE ONLY: CSN #: _____ Probation office: _____ Attorney name: _____